Indiana State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005042 | A. BUILDING _____ B. WING _____ | 10/04/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TERRE HAUTE REGIONAL HOSPITAL | 3901 S SEVENTH ST TERRE HAUTE, IN 47802 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit was for the investigation of a State complaint.<br><br>Complaint # IN00105935<br>Unsubstantiated: Lack of sufficient evidence.<br><br>Facility #: 005042<br><br>Date: 09-19-12 and 10-04-12<br><br>Surveyor:<br>Billie Jo Fritch RN, BSN, MBA<br>Public Health Nurse Surveyor<br><br>Terre Haute Regional Hospital was found in compliance with State Rule 410 IAC 15-1.5-10, Utilization review and discharge planning services.<br><br>QA: claughlin 11/15/12 | S 000 | | |